Office of State PERSONNEL NCFLEX

NCFlex Enrollment Form

Plan Year 2007

Effective Date: _____

EMPLOYING UNIT MUST COMPLETE

Payroll Unit Number: ____ New Employee: ☐ Yes ☐ No Date of Hire/Rehire (mo/day/yr): ____

Payroll Freq: (check ***one***) ☐ Monthly (12 checks per year) ☐ Semi-Monthly (24 checks per year) ☐ Bi-Weekly (26 checks per year) ☐ Bi-Weekly with monthly deductions (26 checks per year) ☐ Other Frequency: _____

Leave Blank

☐ Den ☐ Vis ☐ Sup ☐ Cancer ☐ AD&D ☐ Life ☐ FSA

EMPLOYEE INFORMATION (Please Print)

☐ Male ☐ Female

Name:(Last)_____ (First)_____ MI ____ Date of Birth: mm dd yy ____

SSN: ___-___-____ Daytime Phone: (area code) _____ Agency/Univ/Comm Col: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

DENTAL PLAN

☐ New ☐ Change ☐ Cancel

Plan Options (check one): ☐ LOW OPTION ☐ HIGH OPTION

Coverage Levels (check one): ☐ Employee Only ☐ Employee + One Child ☐ Employee + Two or More Children ☐ Employee + Spouse ☐ Family

VISION CARE PLAN

☐ New ☐ Change ☐ Cancel

Plan Options (check one): ☐ Plan 1 ☐ Plan 2

Coverage Levels (check one): ☐ Employee Only ☐ Employee + Family

SUPPLEMENTAL MEDICAL

☐ New ☐ Change ☐ Cancel

☐ Employee Only ☐ Employee and spouse

☐ Employee and child(ren) ☐ Family

CANCER INSURANCE

☐ New ☐ Change ☐ Cancel **Complete EOI Form Online.**

Plan Options (check one): ☐ LOW OPTION ☐ HIGH OPTION

Coverage Levels (check one): ☐ Employee Only ☐ Employee + Family

DEPENDENT INFORMATION

Name (Last, First, MI) Complete only if enrolling in Sup Med/Dental/Vision/Cancer	Gender M	Gender F	Date of Birth	Full-Time Student Y	Full-Time Student N	Add/Drop		NCFlex Plans Selected: Sup. Medical	Dental	Vision	Cancer
Spouse _____	☐	☐	/ /			☐	☐	☐	☐	☐	☐
Child (1) _____	☐	☐	/ /	☐	☐	☐	☐	☐	☐	☐	☐
Child (2) _____	☐	☐	/ /	☐	☐	☐	☐	☐	☐	☐	☐
Child (3) _____	☐	☐	/ /	☐	☐	☐	☐	☐	☐	☐	☐
Child (4) _____	☐	☐	/ /	☐	☐	☐	☐	☐	☐	☐	☐
Child (5) _____	☐	☐	/ /	☐	☐	☐	☐	☐	☐	☐	☐

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

☐ New ☐ Change ☐ Cancel Complete Beneficiary at Right.

☐ Plan 1 Employee Only

☐ Plan 2 Employee & Family

☐ Aviation Pilot/Crew Member– Plan 1 Employee Only

☐ Aviation Pilot/Crew Member– Plan 2 Employee & Family

Insurance Amount _____ Monthly Cost $ _____

AD&D BENEFICIARY

Full Name(s)	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Primary:		
Contingent:		

VOLUNTARY GROUP TERM LIFE INSURANCE

☐ New ☐ Change ☐ Cancel Complete Beneficiary at Right and **Submit EOI Form Online.**

Insurance Amount _____ Monthly Cost $ _____

TERM LIFE BENEFICIARY

Full Name(s)	RELATIONSHIP TO EMPLOYEE	% OF BENEFIT
Primary:		
Contingent:		

FLEXIBLE SPENDING ACCOUNTS (FSAs)*

(TO CONTINUE YOUR FSA, YOU MUST RE-ENROLL EVERY YEAR)

Annual Health Care FSA Contribution: $_____
(**Annual** minimum $120; **Annual** maximum $4200)

Annual Dependent Day Care FSA Contribution: $_____
(**Annual** minimum $120; **Annual** maximum $5000)

***FSA payments are issued by Direct Deposit to the account your payroll check is deposited.**

☐ **Check here to decline Direct Deposit.**

EMPLOYEE AUTHORIZATION

I hereby elect coverage under NCFlex as listed above for myself and eligible family dependents. I understand that by participating in NCFlex my Social Security Number will be used for tax identification purposes and my pay will be reduced by the amount of my pre-tax elections. **I understand that, in accordance with IRS regulations, I cannot change or cancel my elections or contributions during the Plan Year unless I have a qualifying status change. I understand that any amounts contributed to the Flexible Spending Accounts which I do not use for expenses incurred during the Plan Year will be forfeited.** I certify that the above information is true and accurate to the best of my knowledge.

Employee Signature:_____ Date: _____

FORM 1 (07) **Please make a copy for your records then return completed ORIGINAL form to your Benefits Representative or department.**

S-125 = Y SITUS = NC